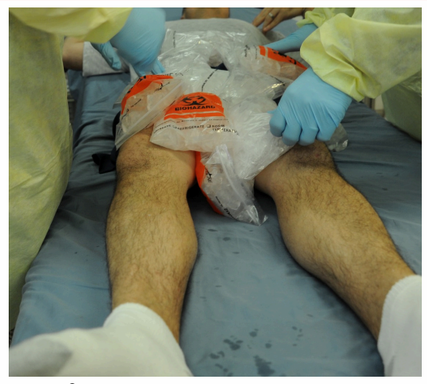
SCGH ED

Drug Induced or Exertional Hyperthermia Pathway

Activation

Not for use in Sepsis!

Temp above > 39.5 = TIME CRITICAL



- With agitated delirium/altered LOC
- Environmental &/or Toxicological cause
- Alert Clinical Toxicologist if suspicion of drug-induced hyperthermia

Send HSA to Theater for more ice

1

Start Active Cooling

- Remove clothing & commence invasive temperature monitoring (Rectal or Oesophageal)
- Grab garbage bags from trauma cupboards & ice from assessment/triage eskies & theater 2nd floor reception.
- Fill bags with ice, add water to create slurry, cable tie bag knot to secure further.
- Then pack axilla, lateral neck, groin +/- as much body surfaces area possible.

2

Rapid Sedation

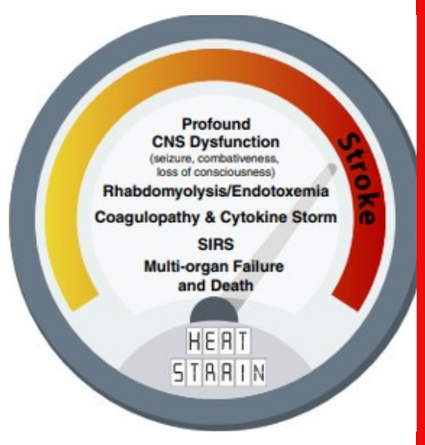
- Immediate control of any agitation is essential to reduce heat generation
- Avoid prolonged physical/mechanical restraint
- First line: Midazolam, Droperidol or Ketamine
- Second Line: Consider proceeding to RSI if unable to control temp/agitation

3

Haemodynamic Support

Be prepared for haemodynamic instability

- Early bedside echo if available
- Fluid resuscitation with cold normal saline
- First line: Noradrenaline
- Second line: Vasopressin - may work better in severe acidosis
- Identify and treat electrolyte disturbance



4

Secure Airway

"Resuscitate before you Intubate"

- Physiological challenges (hypotension, acidosis, metabolic demands)
- Anatomical challenges (trismus)
- Paralytic - Rocuronium
- Aim PcO2 35-40

5

Early ICU Referral

- Consider deep sedation & continuous paralysis
- Watch for complications - Rhabdo, DIC, Electrolyte disturbances, hepatic, renal & cardiac compromise.
- May benefit from extracorporeal support - ECMO/Dialysis

Or STOP once temp <38.5 degrees